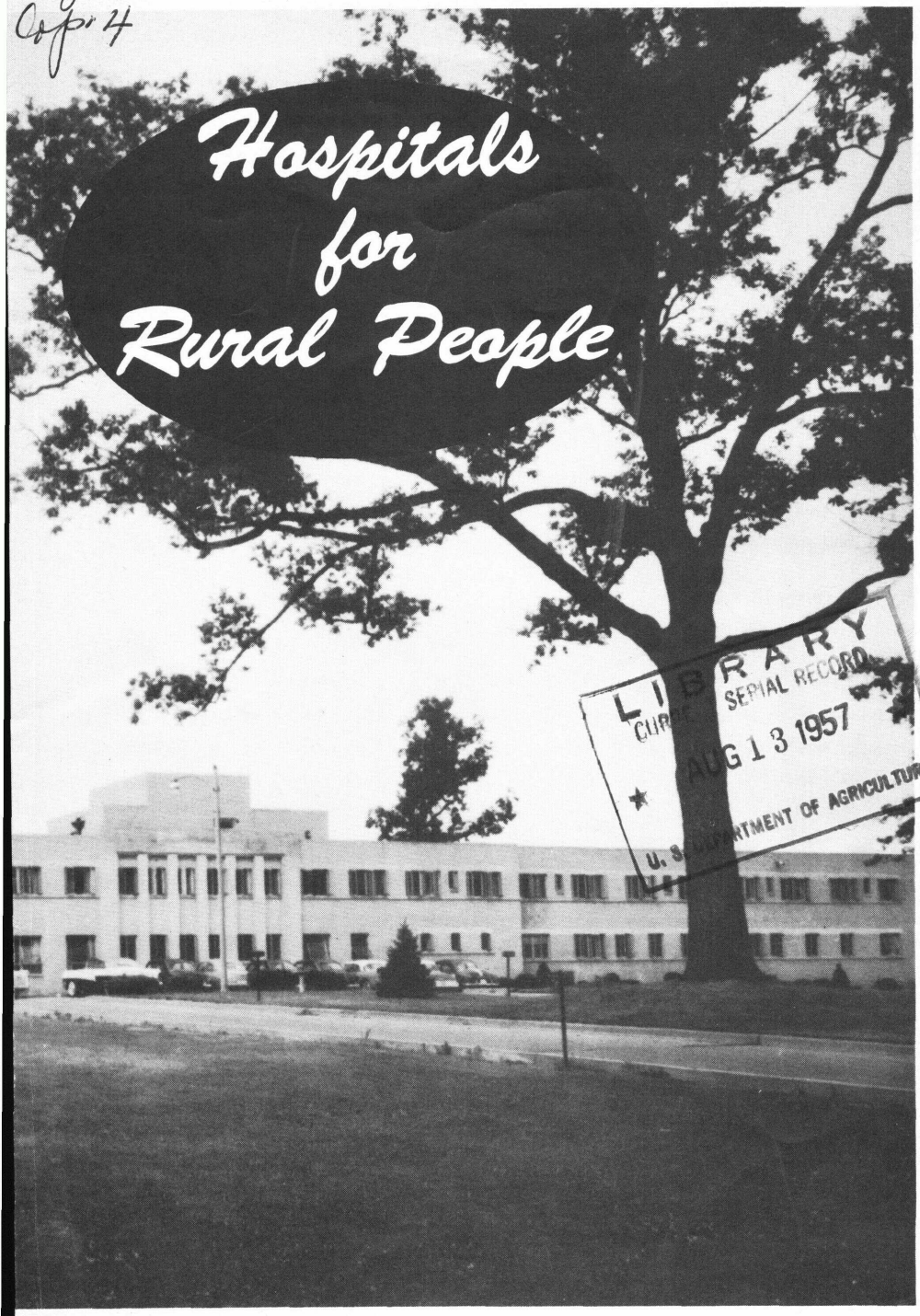
Hospitals for Rural People



Farmers' Bulletin No. 2110
UNITED STATES DEPARTMENT OF AGRICULTURE

Provision for maintenance of health is a cooperative enterprise involving many individuals and community groups. To assure that its health needs—both present and future—can be met, a community needs to appraise its local health services in relation to those in surrounding areas. Are effective methods available for the care and control of illness? Are all people within reach of facilities for the diagnosis and treatment of injury and disease? Are existing health facilities being used by all who live in the service area?

The Farm Population and Rural Life Branch, formerly a Division in the Bureau of Agricultural Economics, has done research and published reports in the field of rural health for many years. The Branch has made a number of surveys on rural health in cooperation with State Agricultural Experiment Stations. A Farmers' Bulletin on rural hospitals was published in 1926. Another Farmers' Bulletin, *Hospitals for Rural Communities*, was published in 1937.

The purpose of this bulletin is to help acquaint rural people with recent nationwide progress in making health facilities available, and to broaden understanding of the possibilities for meeting needs in their own communities. It was prepared by the Agricultural Marketing Service, U. S. Department of Agriculture, with the cooperation and assistance of the Federal Extension Service and the following units of the Department of Health, Education, and Welfare: Office of the Commissioner, Social Security Administration; Division of Hospital and Medical Facilities, and the Division of General Health Services, Public Health Service.

CONTENTS

Cover Picture Description

Lawrence County Hospital, Lawrenceville, Ill., is typical of many hospitals built with Federal aid. The total cost was $971,000, the Federal share was $323,700. This is a 50-bed general hospital and a public health center. Joint housing of hospital and public health facilities increases efficiency and facilitates the coordination of preventive and curative medicine, resulting in better health services for the individual and community. The entrance to the health center may be seen at the left of the main hospital entrance.

Hospitals for Rural People

By Elsie S. Manny, *Social Scientist*, and Charles E. Rogers, *Information Specialist, Agricultural Marketing Service*

In older days, a doctor was seldom called unless somebody in the family was seriously ill. The doctor came with his little black bag. In it were most of the tools of the medical arts that he regarded as essential, besides many of the medicines known to his profession.

By horse and buggy or Model–T he made the rounds of bed patients in their homes. Ministering and advising he transmitted his confidence and comfort to the sick and gave them the benefit of his limited knowledge.

The modern doctor, though he may still make house calls if he is a general practitioner, has far better means to diagnose and alleviate the illnesses that he finds. No longer does he carry with him all the tools of his trade. Present-day medical practice requires the use of the laboratory and X-ray equipment. Without these modern instruments the doctors can make neither complete physical checkups of their patients, nor, in many cases, a diagnosis of the serious diseases attacking mankind. For treatment of many diseases, hospitalization is today essential.

Instead of spending the greater part of his time calling on patients, the modern physician can see most of them in his office, clinic, or hospital. The equipment he needs is there, and he can see many more patients in a day. Physicians now are trained in hospitals that provide modern facilities for prevention, diagnosis, and treatment of illness.

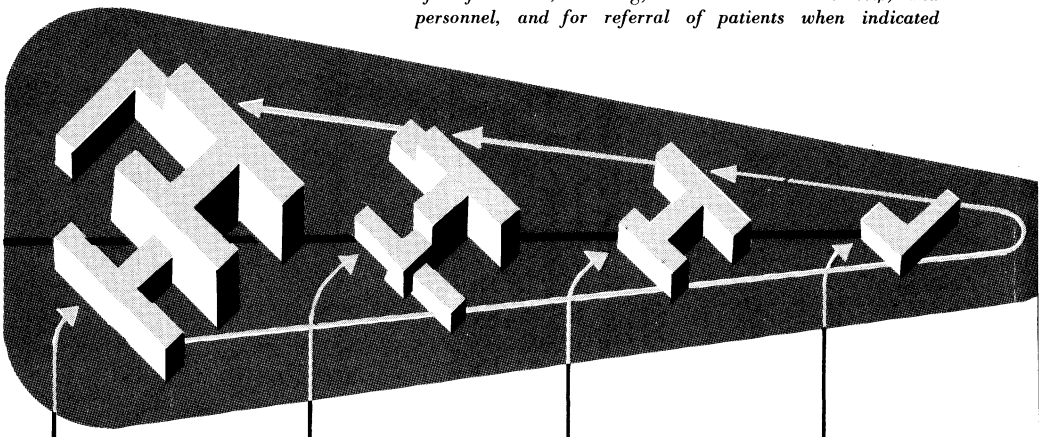
In many rural communities, primary medical equipment and services may be supplied through clinics, sometimes with a few beds—"little hospitals," as it were. There is need to tie in these local facilities with larger hospitals for diagnosis and treatment if the health of the community is to be fully safeguarded. An example of this relationship in medical services, operating since 1935, is the Bingham Associates program, which includes approximately 40 large and small hospitals in Maine and Massachusetts. The diagnostic, research, and teaching facilities of the New England Medical Center in Boston are made available to the general practitioner through regional and community hospitals affiliated with the program.

Hundreds of communities across the country have attained needed medical services. In others, a lack of hospital facilities stands in the way of obtaining adequate medical care. Communities in which doctors do not have access to modern facilities find increasing difficulty in attracting young physicians to replace older practitioners as they retire.

The prevalence of rural accidents is among the factors which point up the need for better facilities within reach of farm families. In 1955, 3,700 farm workers were

COORDINATED HOSPITAL SERVICE PLAN

Plan provides for constant exchange between hospitals of information, training, and consultation service, and personnel, and for referral of patients when indicated



BASE HOSPITAL

Teaching Research Consultation

- Cancer Clinic
- Psychiatric Service
- Heart Clinic
- Major Surgery
- Internal Medicine
- Obstetrics
- Pediatrics
- Orthopedic Surgery
- Communicable Diseases
  - Tuberculosis
  - Venereal Disease
  - Other
- Teaching
  - Nurses
  - Interns
  - Residents
  - Post Graduates
- Laboratory
  - X-Ray
  - Pathology
  - Bacteriology
  - Chemical
- Physiotherapy
- Dentistry
- Eye, Ear, Nose, Throat
- Dietetics

DISTRICT HOSPITAL

- Major Surgery
- Obstetrics
- Internal Medicine
- Communicable Diseases
  - Tuberculosis
  - Venereal Disease
  - Other
- Pediatrics
- Eye, Ear, Nose, Throat
- Dentistry
- Physiotherapy
- Laboratory
  - X-Ray
  - Pathology
  - Bacteriology
  - Chemical
- Teaching
  - Nurses
  - Interns
  - Dietetics

RURAL HOSPITAL and Health Center

- Internal Medicine
- Obstetrics
- Eye, Ear, Nose, Throat
- Dentistry
- Minor and Uncomplicated Surgery
- Laboratory
  - X-Ray
  - Bacteriology
- Administrative Public Health Offices
  - Health Officer
  - Sanitarian
  - Public Health Nurses
  - Public Health Clinics
  - Maternal and Child Health
  - Tuberculosis
  - Venereal Disease
  - Public Health Education

RURAL HEALTH CENT

- Obstetrics
- Emergency Medical and Surg
- Laboratory
  - X-Ray
  - Bacteriology
- Dentistry
- Private Office or Offices for Priv Physicians
- Administrative Public Health Offices
  - Health Officer
  - Sanitarian
  - Public Health Nurses
  - Public Health Clinics
  - Maternal and Child Health
  - Tuberculosis
  - Venereal Disease
  - Public Health Education

As far as buildings are concerned, a major effect of the plan would be seen in rural hospitals and rural health centers. Here too the plan should reach its primary objective—the extension of modern health service to non-unserved areas

REPRODUCED FROM ARCHITECTURAL RECORD

Coordinated Hospital Service Plan.

killed and 310,000 were injured; only the mining and construction industries had a higher death rate per person employed. The total number of farm residents—men, women, and children—killed by accidents was about 14,000, and many more were disabled. Nearly as many fatal accidents occurred in farm homes as in farm work, and even more of the disabling injuries. Highway accidents took a large toll.

Chemicals used in fertilizers, insecticides, and weed killers are farm hazards. Some are poisonous by contact and by inhalation; and some are explosive. Safety precautions are necessary not only in the use but in the storage of these chemicals. When using farm machinery some people are prone to disregard safety rules, and accidents resulting from negligence are common. When accidents happen, time often is vital—being within convenient reach of medical help may mean the difference between life and death.

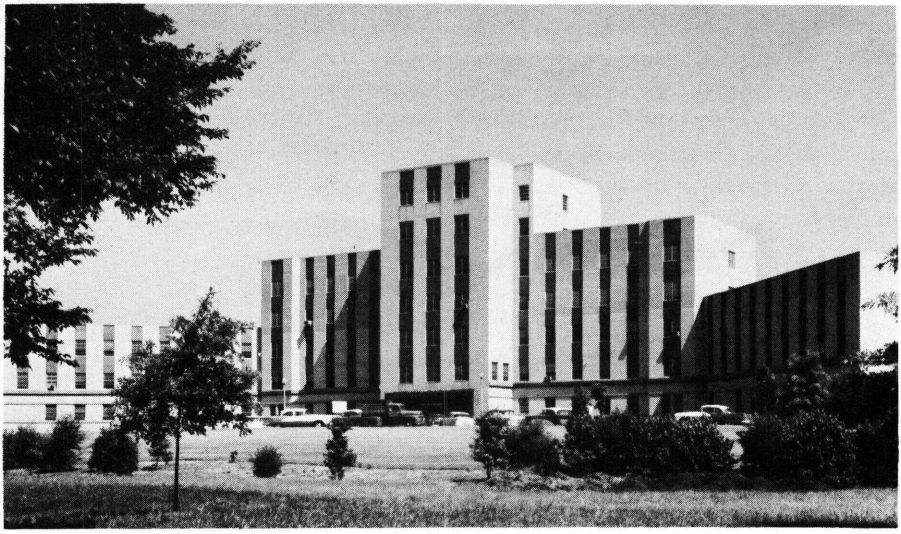
The increasing number of babies born in hospitals emphasizes the importance of having these facilities accessible to rural people. In 1935, only 37 percent of all babies in our country were born in hospitals; in 1954, 94 percent were born in hospitals. For white babies, the percentage was 40 in 1935 and 97 in 1954; for nonwhite babies, the percentage was only 18 in 1935 and 73 in 1954, showing about the same percentage gain in both groups.

How Communities Build Hospitals

Services for farm families were greatly improved through Federal aid provided by passage of Title VI of the Public Health Service Act in 1946—often referred to as the Hill-Burton program. This Act authorized Federal assistance to the States to provide "adequate hospital, clinic, and similar services to all their people." At the end of 1956, 3,234 hospital projects had received financial help or had been approved for assistance under the Act.

Hospitals built with the help of Hill-Burton funds are found from one end of the country to the other. Suwannee County Hospital—36 beds—in Live Oak, Fla., was the first built under the Act, in October 1948; Lebanon Community Hospital—49 beds—Lebanon, Oreg., was the 1,000th completed project, October 1952. An 8-bed addition was made to the Suwannee County Hospital in 1955, just as additions have been made to many other already existing hospitals with the help of Hill-Burton funds.

To be eligible for Federal aid, a State is required to survey existing hospital facilities, outline hospital service areas, and draw up a plan for meeting its needs. Within a State, priority of projects is based on relative need, "giving special consideration to hospitals serving rural communities and areas with relatively small financial resources." More than half of the new general hospitals, assisted with Federal funds, were built in com-



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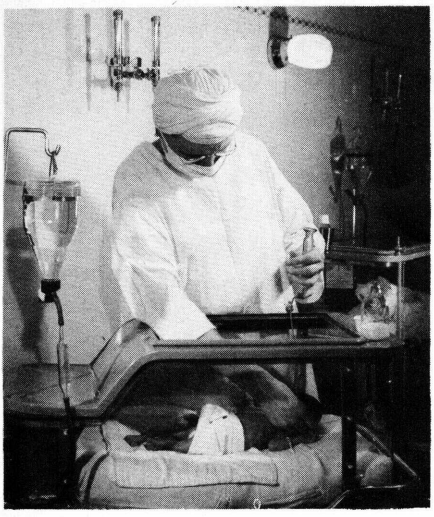
An example of a district or a regional hospital built with Hill-Burton funds is Charleston Memorial Hospital, Charleston, W. Va. This hospital has 274 beds. Its master plan calls for 440 beds. In operation since 1951, it provides for more complete and advanced diagnostic and treatment facilities than are normally possible in smaller hospitals. It has an out-patient department, and it houses a branch of the Charleston-Kanawha County Health Department.

munities of less than 5,000 population, and fewer than a tenth were in cities of 50,000 or over.

In outlining hospital service areas, State plans provide three types of establishments: (1) Large base hospitals with teaching and research facilities, (2) district and regional hospitals, (3) smaller hospitals in rural areas. Between the smaller and larger hospitals lines of communications are established. For health problems beyond its resources, the rural hospital draws on the next larger hospital. This hospital, in turn, refers its most difficult cases to a base hospital. Research and training of hospital personnel are also done by these base hospitals. In addition to hospitals, provision is made by the Hill-Burton Act for assistance in building public health centers, many of which are located in rural areas. Specialists in the large hospitals may give part-time services to these health centers. The accompanying diagram illustrates this plan for the coordination of hospital services.

Federal aid on approved projects varies from one-third to two-thirds of the cost of construction. Twelve States have augmented Federal funds with varying proportions of State aid to build hospitals and public health centers in areas of high relative need. Though many projects are approved for Federal aid, funds are not sufficient to help all cases in need of additional facilities. While some communities finance their local units without Federal aid, others, even when aid



A nurse trained in the care of the premature infant is shown feeding a baby in an incubator by means of a stomach tube. This is a Virginia State Department of Health photograph.

is offered, cannot raise the amount necessary to meet building specifications. In some cases a community goes in with neighboring towns or counties to support a hospital to serve a wide area.

Additional uses of Federal funds are provided in amendments, passed in 1954, to Title VI of the Public Health Service (Hill-Burton) Act. Provision has been made to help finance diagnostic and treatment centers, facilities for the care of patients with chronic illness and disabilities, and rehabilitation facilities. These amendments have stimulated the building of nursing homes, chronic disease wings of general hospitals, and other long-term care facilities. This is in keeping with a growing tendency to treat cases of chronic disease and mental illness in small units and in additions or wings to general hospitals in relatively small communities, rather than exclusively in large specialized hospitals in more urban areas. It enables patients to maintain contacts with home and community even during long-term illness. Help from Hill-Burton funds is now authorized through June 30, 1959.

Building a hospital requires community action. Often a community survey is made to find out if a hospital is needed, in addition to the appraisal required for aid under the Hill-Burton program. Projects are most frequently sponsored by existing or newly formed hospital boards or associations. A nationwide survey made in 1953 indicated that county or municipal governing bodies sponsored about a fifth of the projects. (See *Community Health Action* by Paul A. Miller et al., Michigan State College Press, East Lansing). Sponsoring groups were appointed by local officials or by community-wide elections for the chief purpose of raising money for construction. Their success depended upon help given them by community organizations and groups. Resolving conflicts among factions within the community and neighboring towns and counties was necessary, as well as raising funds. Half of the projects met active opposition because of threatened high taxes.

METHODS OF RAISING FUNDS

More than half of the communities that build hospitals put on local voluntary gift campaigns, and

almost half float county bond issues. Some communities use a combination of methods. Usually a fund-raising campaign is carried on intensively for a short period—1 to 3 months.

Hospital projects aided by Federal funds represent a vast amount of support by local people in addition to Federal aid received.

Fourth of July auctions raised $57,000 for the construction of the 44-bed Hardin County Memorial Hospital in Kenton, Ohio. A bond issue as well as Federal aid was needed to complete the hospital. Auctions continued to help pay for new equipment.

Membership shares in a hospital association helped to finance the 16-bed Lee Memorial Hospital at Giddings, Lee County, Tex. This hospital is typical of many built throughout the State under the Hill-Burton construction program.

In Perryville, Mo., population 5,000, it took three bond issues besides Federal aid and local contributions to build the 55-bed Perry County Memorial Hospital. A group of women known as "hospital volunteers" sewed thousands of items and served as receptionists in the hospital.

The formation of an active Health Council resulted in putting the drive for hospital funds over the top in Taylorsville, Alexander County, N. C. This combination 20-bed hospital and health center is kept operating through volunteer work and contributions.

Cooperative effort of local, State, and Federal agencies made possible the building of the Minnie G. Boswell Memorial Hospital—28 beds—at Greensboro, Ga., in 1948. An addition of 12 beds was built, also with the help of Hill-Burton funds.

Communities can build hospitals without Federal aid. In some instances assistance is not requested; in others aid is not available because the area does not have a high priority rating for the allocation of funds. An individual or group, convinced of the need, promotes the idea until it is supported by the community, and the hospital becomes a reality.

Frequently several financial campaigns are necessary before construction can be started. Local volunteers solicit pledges from individuals, clubs, organizations, and groups. The whole hospital service area is canvassed, and sometimes gifts are received from friends and former residents. Meanwhile the leaders of the campaign may negotiate for help from the county through a bond issue, tax levy, or grant. Health cooperatives or hospital associations, often with prepayment plans, may be organized to help subsidize construction and operating costs. Donations of labor and equipment as well as contributions of time and talent ac-

count for some of the savings realized in local projects.

Following are a few typical examples of community effort in obtaining and operating hospitals without Federal aid; the list could be extended to include hundreds of others.

Volunteer labor helped to make possible a 32-bed hospital in Tigerton, Shawano County, Wis. A health cooperative with a membership fee of $100 gives part ownership, and the opportunity to use the service plan. Cost of service varies from $36 a year for a single member to $81 a year for married members with four or more dependents. The plan covers office calls and treatments as well as hospitalization and other benefits.

The Gothenburg Memorial Hospital—26 beds—in Dawson County, Nebr., was built and equipped in 1949–50 for only $70,000 because local people contributed labor as well as money raised through auction sales, dinners, and other public events.

Under the leadership of a young doctor, Smithville Community Hospital, Clay County, Mo., was built in 1937. Since then eight rooms and other improvements have been added.

A 15-bed hospital in the cotton town of Duluth, Ga., is the result of local initiative plus the financial help of a retired automobile executive. Local people, who had been supporting a small clinic, paid for 24 acres of gullied hilltop and prepared the grounds for the new hospital. The proceeds from a factory helped to support the hospital.

Local labor and the use of Army surplus material reduced the cost of a modern 38-bed hospital in Siloam Springs, Benton County, Ark. Additional funds were raised through a bond issue, farm sales, and numerous other money-raising plans.

Volunteer workmen, under the direction of a local doctor, built the Valley Clinic at Bat Cave, N. C. This clinic serves people living in the mountainous area in parts of four counties—Henderson, Rutherford, Buncombe, and Polk.

Donations of labor, equipment, and materials by local people made the hospital at Faith, S. Dak., a reality.

For each 50 hours of service given to the Madison Valley Hospital—5 beds—in Ennis, Mont., volunteers are credited with a free day of hospital care for themselves or their families. Local people built the hospital, and a young doctor brought in the first equipment.

Built in 1929 through aid from the Commonwealth Fund, the Beloit Community Hospital, Mitchell County, Kans., is kept

operating through volunteer support in addition to patients' fees. The Economy Shop, which sells donated clothing, jewelry, shoes, and other articles, has netted more than $21,000 for new equipment. A banquet, featuring outside speakers, inaugurates the annual financial drive. Interest from an endowment fund, established in 1950, is used for certain other operating expenses.

The "Ten-Acre Wheat Club"—each farmer giving the money made on 10 acres of wheat—helped to raise $200,000 for Kit Carson Memorial Hospital—32 beds—in Burlington, Colo. A 17-man board of local people was set up to formulate plans for erection of a new hospital. When closing his private hospital, a doctor donated the equipment to the new one. Home demonstration clubs made draperies and raised money for painting and furnishing rooms. Women in the hospital auxiliary pay a dollar a year in cash and give as many hours of work as possible. Garden clubs undertook a long-time landscaping plan. Although some help toward maintenance is provided by a small tax levy, farmers, townspeople, and civic and other organizations continue to contribute toward the operation of their hospital just as they did toward its construction.

Two communities joined forces to build the Triumph–Monterey Hospital—16 beds—at Triumph, Martin County, Minn., pictured on page 12. A survey of potential patients showed that 5,000 or 6,000 people would be closer to Tri-Mont than to any other town with a hospital. Following a mass meeting in 1947, a planning committee of 12 was appointed to estimate cost of construction and plan the fund-raising campaign. Later, a 9-member board of trustees was elected, and plans were made to incorporate the hospital. Methods used in collecting $120,000 included the "500 Club" (each member pledging $500), benefit ball games, shows, dances, bake sales, and bequests or memorial gifts. To pay for modern equipment, which cost $30,000, a 20-year trustee fund mortgage was drawn up at 4 percent interest. Sixty $500 notes were subscribed by Tri-Mont businessmen and farmers. At the open house in April 1951, a special bronze medal was given to everyone who joined the "Dollar-A-Month Club." Members signed pledges to pay $12 a year for 5 years. There has been no trouble in attracting doctors and nurses to the staff. The hospital can care for a large proportion of the cases in need of hospitalization in the community.

With maintenance costs increasing each year, financing of hospitals has become a major problem. Building the hospital is just the first step. Total operating expenses of short-term general hospitals in 1955 were equal to more than half the investment in land, buildings, and equipment. The average cost per patient per day to all short-term general hospitals in the country rose from $9.39 in 1946 to $23.12 in 1955, an increase of 146 percent. Salaries paid additional personnel trained in the new procedures, techniques, and services, required as medical science advances, accounted for part of the increase. The number of full-time employees per 100 patients in all hospitals was 30 percent greater in 1955 than in 1946. Annual compensation per employee in all hospitals in the country increased more than 100 percent. About 80 percent of the work in an average hospital is done by women. Before industrial employment competed for women's services, hospitals benefited by the prevailing low wage scale. The entire wage scale required upgrading in an effort to bring it more in line with industry.

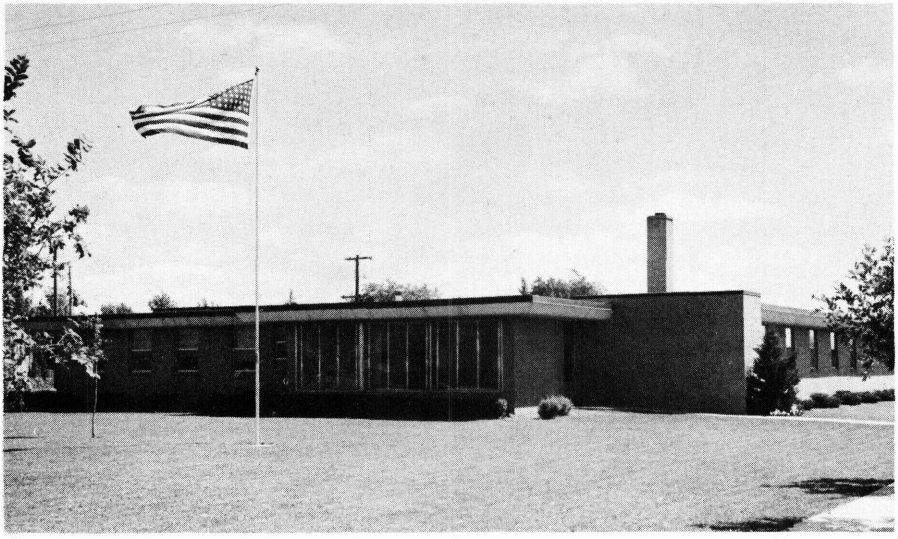
SOURCES OF REVENUE

Because the problem of providing hospital care is a continuing one, many institutions are dependent upon local annual drives for part of their financial support. They receive financial aid from endowments, churches, fraternal organizations, welfare agencies, workmen's compensation funds, grants from community chests, and other agencies and groups. Some hospitals are supported entirely by taxation. Included among these are the publicly supported county, State, and Federal hospitals. Some of these hospitals provide care only for patients with specific illnesses, such as tuberculosis or mental disease. Others provide care for all types of illness, irrespective of the ability of the patient to pay for service.

The chief source of revenue for most general hospitals is the direct payments made by patients at the time of receiving care. However, the former method of paying for hospital services out of cash resources has been supplanted for a large segment of our population by prepayment, that is, the purchase on a regular budgeted basis of hospitalization insurance from voluntary nonprofit organizations such as Blue Closs plans or from insurance companies.

PREPAYMENT OF HOSPITAL CARE

There are two kinds of hospitalization plans—those that pay the hospital directly when a member of a plan has been hospitalized, and those that reimburse the insured patient for part or all of the hospital bill which he has already paid. The former are referred to as "service benefit plans"; they include Blue Cross plans and any other arrangements under which a third party (the plan) pays the hospital bill of members. Plans that reimburse the insured rather than the hospital are



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This 16-bed hospital in Triumph, Martin County, Minn., was built without Federal aid. Local people, convinced of the need for a hospital, raised the entire necessary amount for construction and operation.

called "cash indemnity plans." In general, service benefit plans are preferable, but sometimes people living in rural areas have no choice except an individually purchased cash indemnity plan.

A second distinction among plans relates to the extent to which a plan guarantees to pay all costs incurred in the hospital. Many Blue Cross plans agree to pay the cost of a semi-private room and all or part of the charges for operating room, routine laboratory procedures, drugs and medicines, anaesthesia, dressings and casts, and so on. Other plans, including nearly all sold by insurance companies, provide a fixed amount of benefit, such as $8, $10 or $12 a day, toward each day spent in the hospital, and a fixed maximum toward other hospital charges; these allowances may or may not be sufficient to meet the costs incurred. Plans vary as to the number of days of hospital care they provide as benefits—30, 70, or 120 days are most usual.

METHODS OF ENROLLMENT

Most enrollments in prepaid hospitalization plans are through groups, either at an individual's place of work or through an organization such as a grange, farm bureau, cooperative creamery, or the like. Premiums are lower for the same benefits for a group because of economies in collecting premiums, and because a group is likely to be a cross section of good and bad risks. Individuals and individual families, however, may purchase insurance from many companies and most Blue Cross plans. The latter often open their enrollment for brief periods to individuals who generally must be under 65 years of

age. Almost all Blue Cross plans periodically conduct enrollment campaigns on a community basis.

A successful example occurred in Haywood County, N. C.—the Haywood Community Development program sponsored a campaign in 1951. In order to qualify, it was necessary to sign up 75 percent of all families in the community. Hospital Care Association of Durham, N. C., was the underwriter with a Blue Cross plan for hospitalization. There is coverage for surgical care and for some other in-hospital medical expenses. The Mississippi Hospital and Medical Service has conducted a program of community enrollment in 39 counties from 1950 to 1955. The local community hospital provided the center for the enrollment drive. Iowa, Colorado, and Kansas are among other States in which community enrollment techniques have been used to extend coverage to rural families.

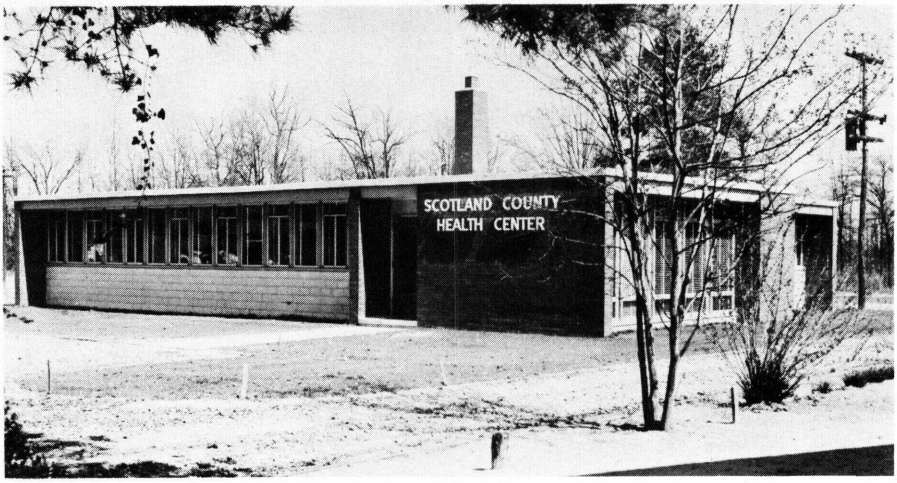
THE ROLE OF PREPAYMENT IN FINANCING HOSPITAL CARE

In 1955, Blue Cross plans provided service benefits for more than 48 million people in the United States; their more than 6,000 member-hospitals received $832 million in payments for care of their subscribers, or about $17–$18 per subscriber. In fact, a third of all revenue of all general hospitals in the United States came from Blue Cross plan (third-party) payments. Some Blue Shield plans, notably on the West Coast, provide hospitalization insurance as well as surgical expense and in-hospital medical expense insurance, the type of insurance offered by Blue Shield plans all over the United States. Insurance sold through group insurance company hospitalization policies covered 39 million people at the end of 1955, and 27 million people had individual hospitalization policies issued by insurance companies. Insurance companies paid their policyholders more than $700 million toward their expenses for hospital care. Altogether, prepayment met about half the costs of hospital care financed privately in the United States in 1955.

The extent to which prepayment finances hospital care would be even greater if the third of the population not now insured had this protection. People without a common employer, persons over 65 years of age, and those with relatively low incomes are less likely than others to be insured. In rural areas, which have a large proportion of self-employed people and where incomes are subject to year-to-year fluctuation, enrollment is relatively low.

PREPAYMENT OF MEDICAL SERVICES

So far the discussion has focused on sources of financing the cost of hospital care. A hospitalized illness involves many other kinds of expenses including the charges of surgeons and physicians. Those concerned with the finances of hospitals cannot ignore the problems



Scotland County Health Center, Laurinburg, N. C., near the border of North and South Carolina, is similar to hundreds of centers built in the South with the help of Federal funds. Total cost of this center was $46,018; the Federal share was $15,646.

patients have in paying for the medical care needed while ill.

A number of rural communities have provided a solution to both problems through health cooperatives which provide both hospital care and medical care. The oldest rural cooperative hospital is at Elk City, Okla. Established in 1929, it is operated by the Farmers Union Hospital Association. It provides not only hospital care and physicians' and surgeons' services to its members but out-patient care, including preventive medicine. Dental care at cost is also provided.

Other rural health cooperatives have been formed in the southwestern States, including several in Texas. Benefits vary somewhat, but home and office care as well as care in hospitalized illness is provided members.

A survey of medical costs and voluntary health insurance through family interviews, conducted by the Health Information Foundation in 1953, revealed that medical care expenditures other than those for hospitalization, surgery, and obstetrics accounted for about half of the payments made for physicians and hospitals, and showed the small extent of prepayment available for these services. In planning a health program to meet the needs of a community the value of prepayment for day-to-day care and preventive and diagnostic services should be kept in mind. Where comprehensive prepayment arrangements have not been developed, Blue Shield plans provide surgical and in-hospital medical expense insurance. This is a service benefit to subscribers whose income is less than a stated amount. Insurance company cash indemnity plans also may be available to assist rural families in budgeting against these types of medical care expenses.

Plans sponsored by medical associations in California, Idaho, Oregon, and Washington cover home and office visits of physicians as well as hospitalized illness. Other group plans on the West Coast include the Kaiser Foundation Health Plan, which provides comprehensive health care through its own system of hospitals and clinics. On the East Coast the Health Insurance Plan of Greater New York has recently extended its coverage to rural Columbia County, through the Rip Van Winkle Clinic in Hudson, N. Y.

As the Hospital Survey and Construction Act surveys have demonstrated, health facilities are not as readily available to rural as to urban population. People with relatively low incomes are less likely to receive health services than those with high incomes. If more low income families were insured, the benefits of modern medicine will become more widely available. Efforts by a community to provide prepayment in connection with the construction of a health facility will bring improved health and greater productivity to rural families.

OTHER COMMUNITY HEALTH RESOURCES

PUBLIC HEALTH CENTERS

More than 650 public health centers have been built with Federal aid through the Hill-Burton Act—502 in the South. Although the trend has been toward the organization of public health units on a district rather than on a single-county basis, the latter continues to be the most prevalent type.

In spite of the improvement made in local public health facilities, the rate of expansion in the geographic coverage of local health units has been very slow during the past few years. In 1950, 68 percent of the counties which included approximately 86 percent of the total population of the United States were organized for full-time local public health services. By 1955, the proportion of counties and population in organized areas had increased by only 3 percent.

Recent growth in full-time staffs of local health units evidenced from year to year has been slight. Because of the rapid increase in population, augmentation in staff has not been great enough to raise the ratios of public health workers to population served. Rather, the national staffing situation reflects a downward trend in these ratios—the ratio of full-time public health workers employed by local health units in 1954 was 26.4 per 100,000 population, compared with 31.3 in 1950.

Public health services must compete with other needs, such as schools and highways, for public support. Many communities, however, find that a public health center contributes greatly to such preventive measures as prenatal care, well-baby clinics, immunization programs, laboratory tests, and community sanitation. Needless disability or early death from heart disease, cancer, and other dreaded

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Mankato Clinic, located in north central Kansas, is typical of many clinics built to provide doctors with needed equipment.

illnesses may be prevented by early diagnosis and treatment. Cooperation between counties in securing public health services is found in North Dakota and other States in the Northern Great Plains. The formation of health districts consisting of several counties, or a city and its surrounding county, is being used in some places as a means of providing more complete local public health services.

The work of public health personnel is being extended through the use of other community resources. Coordination of the health work of official and voluntary agencies is of increasing importance. The role of the public health physician is broadening to that of a community leader, working through existing organizations to meet current health problems.

An example of cooperation between home demonstration clubs and the county health department is found in the western part of Edgecombe County, N. C., where five communities worked together in building and equipping a public health clinic which is serviced by county public health personnel on certain days each week. The health leaders of local clubs help with the home demonstration programs, supply materials for the study of nutrition in the schools, conduct first aid and home nursing courses, and carry on other health activities. Health is emphasized in relation to proper nutrition, housing, sanitation, and immunization. Through-

out the area, families are adopting preventive measures to improve their health.

CLINICS

Clinics built to attract a doctor to an area are not confined to any one State. Many are found in Kansas and Virginia, where the State medical schools cooperate with local communities in obtaining physicians. The clinic at Mankato, the county seat of Jewell County, Kans., is shown on page 16. Built according to the chosen doctor's plan, this clinic consists of a large reception room, office for receptionist-secretary, doctor's consultation room, three treatment rooms, a utility room which contains the heating system, X-ray and dark room, and storage for laboratory supplies. The clinic also has a well-equipped ambulance. Arrangements were made for the doctor to buy the clinic, on easy payments, without interest, and donations of time and material reduced the cost of construction to $9,000.

Frequently, clinics are built with a few beds for emergency and obstetrical cases. For example, in Hanover, Washington County, Kans., a $30,000 health center was built, including offices for doctor and dentist, plus six hospital beds and four bassinets. The clinics just described are not eligible for Hill-Burton construction aid, since private profit is possible in their operation.

Clinics built by several doctors practicing as a group are becoming more prevalent in rural as well as urban areas. A doctor and his two sons built a clinic in Waverly, Lafayette County, Mo., which serves people within a 50-mile radius.

Mobile clinics are used in some areas to take services to rural people. For example, Delaware uses (1) a mobile X-ray unit in the examination of school children for tuberculosis, and (2) a mobile cancer unit which serves as an extension of the cancer clinics and emphasizes the value of regular physical examinations. In New Jersey, mobile clinics treat agricultural migrant workers for venereal diseases. Mobile dental clinics operate in several Tennessee counties.

TOWARD BETTER HEALTH

People's response to appeals for improved health services are widely varied. Some are based upon rather intangible causes, such as folklore, tradition, and deeply imbedded beliefs that influence attitudes and behavior. More tangible influences are such considerations as distance from medical facilities, the age of people who have need of health services, whether they are men or women, and their income. Local customs and standards of health often have a bearing. And to some people suggestions for improving the health of the community will mean more than plans for bettering their own personal health. In practice, programs promoted on a community basis often encourage some residents to carry out improved health practices in their own homes.

COMMUNITY HEALTH PROGRAMS

Community development programs sometimes include activities to improve the health and safety of all families who live in an area. These have been strongly emphasized in the South. In such community endeavor, business groups and farmers' organizations take the lead in sponsoring contests and offering prizes to the community that makes the most improvements during the year. Civic clubs, farm agencies, public officials, institutions, and individuals work together to achieve goals.

Community projects related to health include promoting safety in the home and on the farm, making improvements in home conveniences, sanitation and recreation, sponsoring tests for cancer and TB, building clinics, and obtaining fire-fighting equipment. Indirectly related to the health of the community are programs to improve schools, churches, community playgrounds, roads, telephone service, and agricultural products. Establishment of better rural-urban relationships may be a byproduct of these programs.

SPONSORING OF DIFFERENT TYPES OF FACILITIES

Experience shows that women's groups are generally most active in campaigns for public health centers; men's civic groups are most active in hospital drives. To get people to see the importance of the preventive work of a public health center requires educational work. Some shy away from "public health," not realizing how much these programs relate to the wellbeing of their families. There has been some tendency toward providing joint housing for hospital and public health services. This may help to associate the preventive and curative aspects of medicine.

Obtaining a hospital is a financial venture in which businessmen may be best prepared to take the lead, but assured success requires the support of all groups. A hospital is easier to dramatize than a public health center or a clinic. But the financial outlay for a hospital is vastly greater. Some communities that start out to build a hospital decide that a clinic containing a few beds or a public health center best meets their needs.

HOW WILL IT BE FINANCED?

In deciding on any project for new facilities—whether hospital or public health center—it is important to consider whether funds will be available to pay salaries of personnel and to meet operating and maintenance expenses, as well as to defray the first cost of building and equipment. Communities raise funds in different ways, depending upon locality and resources. Bond issues, taxes, association dues, annual financial drives, voluntary gifts from individuals, institutions, groups, and organizations, as well as payment for services—all are methods that are used. Raising enough funds often requires several campaigns in which different methods are used. Hospital service areas on the Pacific Coast frequently incorporate into a hospital

district for the purpose of issuing bonds to build and maintain a hospital.

Professional fund raising agencies are costly, but usually the financial goal is reached more quickly when they are employed than when only volunteer leaders are used. Case histories indicate that when local people take full responsibility for the campaign, they have a keener interest in the project and are more likely to support the hospital after it is built.

COMMUNICATION MEDIA

A sponsoring group tries to represent all sections of a service area and keep in touch with them during a campaign. Appeals arouse and encourage active participation through newspaper articles, street corner discussions, speeches, hand bills, posters, and radio programs. Local leaders often call in technical assistance from professional agencies, particularly to help select the site, to develop blueprints, and to assist with problems of construction and of requirements of ownership and administration. Upon completion, most hospitals are owned either by a nonprofit association, newly formed or already existing, or by a county or city government.

FAMILY DOCTOR AND SPECIALIST

In spite of increased specialization in medicine, the general practitioner is a vital link in the chain of health services. When several doctors set up practice together in a clinic, the personal relationship of the physicians with their patients may be maintained together with opportunity to perform specialized services. Doctors in group practice sometimes work out prepayment plans for medical care.

One means of coordinating medical care is achieved by having the services of specialists available from city hospitals, on a part-time basis, in public health centers, clinics, and small hospitals in rural areas.

OPPORTUNITIES FOR LOCAL INDIVIDUALS AND GROUPS

Improvement of local health involves cooperation between individuals and groups supplying health services and the people who need them. Farm families can help bridge the gap between medical resources and their use. Even one individual or family can give the impetus necessary to enlighten a community to its needs. It often opens the way to opportunities available for obtaining better health through the use of existing services or through their expansion.

People do overcome difficulties and discouragement, and then work on to the fulfillment of their dreams of better health facilities, as thousands of community hospitals and public health centers testify.

But what can an individual do if new health facilities are needed in his community?

1. The first step, of course, is to interest other individuals and agencies concerned. These may be a local doctor, a health council, county or State health officers, county or

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This 40-bed Cerebral Palsy Hospital at Durham, N. C., was built with Federal aid.

State medical associations or State health specialists, or a community organization or group in which health is one of its special concerns. State and county extension services frequently can be helpful in supplying data and in organizing a group to study the facts and make plans for a project. Meeting together, the group decides on an objective and coordinates efforts for attaining it. A representative from the State Board of Health or State Hospital Construction Agency, who is familiar with the State survey for the Hill-Burton program, should be invited to outline the overall plan for health facilities. The plan will help the community to fit its program into the State picture. Other communities may be interested in joining the project. Discussion may bring out the fact that adequate facilities are already available and not fully used. An educational program may be what is needed. County or community self-surveys are often helpful in providing basic facts about needs for facilities, health education programs, or other health projects.

2. The objective will be determined by conditions within your own community or county and neighboring areas. Both present and future local needs for services should be appraised as well as existing services and plans for services in neighboring communities. Not only the cost of building any new facility, but of operation and maintenance as well, must be considered. Is the population rather stable or one that is changing rapidly? It

may be necessary to do some joint planning with adjacent counties or communities to include enough people to support the project. Better transportation to a health facility may be what is most needed. When calculating the distance to a hospital, the length of time required to get there is more important than the number of miles. Good year-round roads and ambulance service widen the area that a hospital can serve.

In sparsely settled regions, a plan has been proposed to station ambulances at outpost clinics which are under the direction of a hospital, for quick transportation of patients to hospitals. To have every family within reach of hospital and other needed health facilities is the goal. To work out plans for attainment which meet conditions in rural areas is the task. Building an all-weather road to shorten the travel time to the nearest hospital might be more effective—and less costly—than building another small hospital. The Public Health Service through State and local health departments, and other agencies through State and county workers, are ready to help a local group work out plans in accordance with local needs.

3. If your community desires to build a hospital or public health center or any of the other kinds of health facilities recently made eligible for Federal assistance, apply to your State hospital construction agency for information and advice about defining the services required. Many of the State agencies have available summary material on individual hospitals built in the State, as well as general guide materials on suggested floor plans, equipment, and the staffing. At the end of this bulletin you will find the name and address of the hospital construction agency in your State. Each community will need to employ its own architect to develop specific building plans.

4. If a building program is decided upon, a sponsoring group representative of all segments of the area to be served may be appointed. This group enlists support and raises funds. It explores possibilities of county, State, and Federal aid. Not infrequently, funds from philanthropic foundations are available. The Duke Endowment, for example, gives aid in the operation of hospitals in small communities in North and South Carolina.

5. Help from professional groups can be secured in obtaining personnel for the facility. State and county medical associations, nurses' associations, public health officers, health workers in the university extension service, and others can be approached. If a clinic is built, local health personnel can be supplemented by visiting specialists from a hospital, who can spend certain days each week at the center to care for local patients. Large hospitals, where personnel are taught and trained, sometimes help small hospitals to get the services of doctors on a full- or part-time basis.

Although staffing is often a serious problem, experience shows that doctors and nurses are attracted to a new hospital. In a study of hos-

pitals built in small communities under the Hill-Burton program, 2 of every 5 professional nurses had been retired but resumed nursing because the hospital was in their home town and they wished to relieve the shortage.

6. The next step is to work out a plan that will enable people to pay for the hospital services they need. Enrollment in prepayment plans may be developed by a county cooperative health or hospital association, by a nonprofiit association, such as Blue Cross, or by insurance companies using the county or community as a basis for enrollment. Some localities enroll most of the residents through employed groups and farmers' organizations.

7. Educational programs may be promoted to make people aware of health needs and goals. Good individual and family health practices begin in the home and extend into the community. Programs in schools and clubs may be planned (1) to encourage effective use of available medical services and (2) to awaken the community to obtain additional facilities which may be needed.

Good health is probably the most important asset of an individual, a family, a community, and the Nation. United effort—local, State, Federal—can accomplish much in bringing health facilities and services to all our people.

State Agencies Administering the Hospital Survey and Construction Program

ALABAMA State Department of Health, Montgomery
ALASKA Department of Health, Juneau
ARIZONA State Department of Health, Phoenix
ARKANSAS State Board of Health, Little Rock
CALIFORNIA State Department of Public Health, Berkeley
COLORADO State Department of Public Health, Denver
CONNECTICUT State Department of Health, Hartford
DELAWARE State Board of Health, Dover
DISTRICT OF COLUMBIA Department of Public Health, Washington, D. C.
FLORIDA Development Commission, Tallahassee
GEORGIA Department of Public Health, Atlanta
HAWAII Territorial Department of Health, Honolulu
IDAHO State Board of Health, Boise
ILLINOIS Department of Public Health, Springfield
INDIANA State Board of Health, Indianapolis
IOWA State Department of Health, Des Moines
KANSAS State Board of Health, Topeka
KENTUCKY State Department of Health, Louisville
LOUISIANA State Department of Hospitals, Baton Rouge
MAINE Bureau of Health, Augusta

MARYLAND State Department of Health, Baltimore
MASSACHUSETTS Department of Public Health, Boston
MICHIGAN Office of Hospital Survey and Construction, Lansing
MINNESOTA Department of Health, St. Paul
MISSISSIPPI State Commission on Hospital Care, Jackson
MISSOURI Department of Public Health and Welfare, Jefferson City
MONTANA State Board of Health, Helena
NEBRASKA Department of Health, Lincoln
NEVADA State Department of Health, Carson City
NEW HAMPSHIRE State Health Department, Concord
NEW JERSEY State Department of Institutions and Agencies, Trenton
NEW MEXICO Department of Public Health, Santa Fe
NEW YORK Joint Hospital Survey and Planning Commission, Albany
NORTH CAROLINA State Medical Care Commission, Raleigh
NORTH DAKOTA State Department of Health, Bismarck
OHIO Department of Health, Columbus
OKLAHOMA State Department of Health, Oklahoma City
OREGON State Board of Health, Portland
PENNSYLVANIA State Department of Welfare, Harrisburg
PUERTO RICO Department of Health, San Juan
RHODE ISLAND Department of Health, Providence
SOUTH CAROLINA State Board of Health, Columbia
SOUTH DAKOTA State Department of Health, Pierre
TENNESSEE Department of Public Health, Nashville
TEXAS State Department of Health, Austin
UTAH State Department of Health, Salt Lake City
VERMONT Department of Health, Burlington
VIRGIN ISLANDS Department of Health, St. Thomas
VIRGINIA Department of Health, Richmond
WASHINGTON State Department of Health, Seattle
WEST VIRGINIA State Department of Health, Charleston
WISCONSIN State Board of Health, Madison
WYOMING State Department of Public Health, Cheyenne

Issued June 1957

This publication supersedes Farmers' Bulletin 1792, "Hospitals for Rural Communities."

U. S. GOVERNMENT PRINTING OFFICE: 1957 O—423402

For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. — Price 10 cents